Department of Family and Protective Services and Department of State Health Services Joint Report on Senate Bill 44

December 2014

Companion to Needs Assessment: Examining the Relinquishment of Children with Serious Emotional Disturbance

Conducted by the University of Texas at Austin

Executive Summary

Senate Bill 44 (83rd Legislature, 2013, codified in Texas Family Code Chapter 262, Subchapter E), directed the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS) to jointly study and develop recommendations to prevent the practice of parents relinquishing custody of children with a severe emotional disturbance to the conservatorship of DFPS solely to obtain mental health services for the child.

DFPS and DSHS contracted with the Child and Family Research Institute at the University of Texas at Austin to conduct a needs assessment on the topics identified in S.B. 44. The needs assessment has been used to inform the DFPS and DSHS Joint Report on S.B. 44.

The joint report discusses the state's current public mental health system and how these initiatives and services prevent, intervene, and treat serious emotional disturbance (SED) in children and youth, thus decreasing parental relinquishment due to a SED. Additionally, the report discusses barriers to services that still exist. The report also outlines a number of recommendations for consideration as follows:

- continue the current DSHS and DFPS services and initiatives geared toward prevention, early intervention, and treatment of SED in children and youth;
- increase the number of residential treatment center beds for the DFPS/DSHS Residential Treatment Center Project;
- explore expanding Community Resource Coordination Groups in high risk areas;
- continue to expand the Youth Empowerment Services (YES) waiver;
- expand emergency crisis and respite services;
- expand mental health training opportunities for professionals who have frequent contact with children such as DFPS child protection caseworkers, educators and law enforcement;
- increase DFPS consideration of Joint Managing Conservatorship for families who meet statutory criteria; and
- make information on parental rights regarding relinquishment more readily available.

S.B. 44 directs the executive commissioner of the Health and Human Services Commission to review the recommendations developed and allows for any recommendation to be implemented where existing resources are available. S.B. 44 requires DFPS and DSHS to update the report each even-numbered year after the date the initial report is filed, including the implementation status of each option recommended in the original report.

Legislative Background and Requirements

Senate Bill 44 (83rd Legislature, 2013, codified in Texas Family Code Chapter 262, Subchapter E), directed the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS) to jointly study and develop recommendations to prevent the practice of parents relinquishing custody of children with a severe[1] emotional disturbance to the conservatorship of DFPS solely to obtain mental health services for the child.

As part of the study, the law requires DFPS and DSHS to consider the advantages of providing mental health services using temporary residential treatment and intensive community-based services options, including:

- diversion residential treatment center services;
- the YES waiver program;
- systems of care services;
- emergency respite services; and
- Joint Managing Conservatorship of the child by DFPS and the child's parent.

The law further requires DFPS and DSHS to file a report with the legislature and the Council on Children and Families on the results of the study DFPS and DSHS conducted. The report must include:

- each option to prevent relinquishment of parental custody that was considered during the study;
- each option recommended for implementation, if any;
- each option that is implemented using existing resources;
- any policy or statutory change needed to implement a recommended option;
- the fiscal impact of implementing each option, if any;
- the estimated number of children and families that may be affected by the implementation of each option; and
- any other significant information relating to the study.

The two agencies are required to update the report each even-numbered year after the date the initial report is filed, including the implementation status of each option recommended in the original report to the Legislature.

In addition, the executive commissioner of the Health and Human Services Commission (HHSC) must review the recommendations developed and may direct the implementation of any recommendation that can be implemented using existing resources.

[1] The mental health field uses the term serious emotional disturbance rather than the terminology in Texas statute which is "severe emotional disturbance." For the purposes of this report, we are using serious emotional disturbance to maintain consistency with literature from the mental health field.

DFPS and DSHS contracted with the Child and Family Research Institute at the University of Texas at Austin to conduct a needs assessment on the topics identified in S.B. 44. The needs assessment has been used to inform this report.

This report will discuss the state's current public mental health system and how these initiatives and services prevent, intervene, and treat serious emotional disturbance (SED) in children and youth, thus decreasing parental relinquishment due to a SED. Additionally, this report will discuss barriers to services that still exist. Finally, this report will provide recommendations to further reduce this issue in the state.

Definition of Serious Emotional Disturbance

A serious emotional disturbance, or SED, is defined in Texas as a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits the child's role or ability to function in family, school, or community activities. In Texas, DSHS estimates that 156,390 children ages 9-17 years have SED.

While child abuse or neglect may be correlated with SED in some cases, there are various contributing factors that can lead to the development of SED. These can include biological factors (genetic, biochemical, and neurological influences), such as prenatal drug exposure, brain damage or dysfunction, malnutrition, or physical illness. Additionally, there are the psychosocial elements (relationships, family, and community) which may include poverty, trauma, domestic violence, abuse, neglect, parental stress, inconsistent expectations and rules, peer group, and neighborhood characteristics.

Untreated mental health disorders and SED can lead to suicide attempts. Over 90 percent of children and youth who commit suicide have a mental health disorder.[2] Psychopathology, particularly mood disorders, conduct disorders, and substance abuse, are strongly associated with youth suicide.[3] Appropriately treating children and youth with these disorders can decrease the risk of attempting suicide, while also decreasing the risk of parental relinquishment of custody.

Introduction

Alexandra's[4] parents had been involved with DFPS many times. By age five, Alexandra was removed from them along with her younger brother and permanently placed with her grandparents. Alexandra soon began to exhibit severe emotional and behavioral problems. Her grandparents sought assistance from numerous health educational and mental health resources in their community.

While services and consultations occurred for many years, Alexandra's behaviors worsened. In adolescence, Alexandra exhibited symptoms of bulimia, threatened to kill her younger brother, hit her grandparents, cut herself, used marijuana and alcohol, and attempted suicide, which resulted in multiple psychiatric hospitalizations. Over the years, there were times when

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[2] Shaffer, D., & Craft, L. "Methods of Adolescent Suicide Prevention." *Journal of Clinical Psychiatry*, 60 (Suppl. 2), 70-74, 1999.

[3] http://www.nami.org/Content/ContentGroups/Illnesses/Suicide_Teens.htm

[4] Name has been changed to protect confidentiality.

Alexandra's grandparents thought that they may need to relinquish custody to DFPS to obtain the mental health services that she required. However, it was not until Alexandra seriously injured her younger brother by choking him that her grandparents determined that they had exhausted all efforts and the only solution was relinquishment.

Eventually, Alexandra's family was reported to DFPS because of the high-risk situation. No child abuse or neglect was found; however, DFPS identified that Alexandra might be appropriate for the DFPS/DSHS Residential Treatment Center (RTC) Project.

In the RTC Project, DSHS and DFPS collaborate to prevent parental relinquishment of custody of children with a SED to DFPS solely to obtain mental health treatment. Referrals originate from DFPS, and DSHS receives the referrals and coordinates mental health assessments for the children with their Local Mental Health Authority (LMHA). Children who do not meet RTC criteria are offered outpatient services by the LMHA, while those who do meet RTC criteria are offered outpatient services while awaiting RTC placement. (See Appendix C for more details regarding the RTC Project.)

Alexandra was accepted into the RTC project and placed. After six months, she displayed a significant decrease in SED symptoms and demonstrated newfound insight and maturity. Her relationship with her grandparents became more positive for all of them. Alexandra was successfully discharged to her family and soon thereafter enrolled in wraparound services at the LMHA.

> *"I realized I have to change to be successful in my stay here [in an RTC]. I started to progress and each day was another day of a new start. I have progressed so much here. My perspective on life has changed."*
> *–Alexandra, an adolescent youth who received RTC services through the collaborative DFPS/DSHS RTC Project*

Throughout Texas, numerous parents/guardians of children with SED face a heart-wrenching dilemma when they consider whether to relinquish custody of their child to DFPS in order to obtain needed mental health services. Alexandra's story represents common experiences of these families.

Current Initiatives and Services

DSHS and DFPS both provide prevention services to address SED, and DSHS also provides early intervention, and treatment. The initial objective is to prevent the occurrence of SED in the first place. The second is to raise awareness of SED and provide training to identify and address it early in its course. The third is to provide treatment to those children and youth who have developed a SED. When properly treated, these children and youth can recover, remain in their own homes and communities, and live full and productive lives. When SED is prevented, identified early and intervened upon, or treated effectively, parental relinquishment secondary to SED is no longer a consideration for these children and youth.

Prevention

Early mental health promotion and early intervention programs can help reduce the occurrence of SED, among other poor outcomes. This reduces the need for parental relinquishment due to SED. DSHS and DFPS provide a variety of prevention services.

DSHS prevention services include Youth Prevention and substance abuse training and initiatives. Some of these services prevent SED and other poor outcomes by addressing good prenatal care and educating parents on early childhood development and care. Other services provide substance abuse interventions to assist pregnant women and parents in staying substance-free, in addition to providing parent skill training. Research indicates that babies who are healthy are at reduced risk for SED later[5]. A healthy early environment for children can curtail the likelihood that SED develops later, or nurture a context in which families are better equipped to support a child with more mild mental health issues so that the problems never become severe. Other programs address risk factors in children and youth, such as substance abuse, that could exacerbate SED and potentially contribute to their relinquishment.

DFPS, through its Prevention and Early Intervention (PEI) program, provides prevention services that help address SED. The Services to At-Risk Youth program provides crisis intervention counseling, emergency respite care and counseling to eligible families with youth up to age 17. Community Based Family Services serves families who are investigated by CPS and are at risk of child abuse or neglect, though allegations are not confirmed and risk is determined to be low. Services include home visits, case management, and additional social services. The Texas Families: Together and Safe program funds evidence-based, community programs to relieve stress and promote parental skills and behaviors that increase the ability of families to be independent and nurture their children. See Appendix A for details regarding DSHS and DFPS prevention services.

Early Intervention

Early identification of medical, developmental, and behavioral health issues is critical to the long-term well-being of children, reducing the incidence of SED. DSHS has a number of initiatives to increase public awareness of mental health symptoms, decrease stigma, and train educators and community members to identify at risk youth. Examples include developing online training aimed at helping schools identify and refer students who may need mental health services and implementing public awareness campaigns related to the problem of mental illness and substance abuse disorders among teens and young adults. When behavioral health warning signs are identified early and intervention occurs soon, SED may not develop, thus reducing the need for parental relinquishment due to SED. Specifically, these initiatives include the Speak Your Mind Campaign, Mental Health First Aid (MHFA), and At-Risk Training. See Appendix B for details regarding early intervention services.

Treatment

Even with prevention and early intervention, some children will develop SED and require intervention and treatment. It is especially important for children with SED who have

[5] Source: Building a Comprehensive System to Address Infant and Early Childhood Mental Health Disorders. A Zero to Three Policy Center Policy Brief (January 2007).

experienced physical and sexual abuse to receive treatment as the experience of physical and sexual abuse during childhood has been associated with an increased risk of suicidality in adulthood. Analysis has shown that the prevalence rate of lifetime suicide among non-abused individuals is lower than the rates demonstrated by individuals who have experienced physical abuse, sexual abuse, and both abuse types.[6] Many children with SED at risk of parental relinquishment of custody have experienced one or more types of abuse by former caregivers or family members. Receiving appropriate mental health treatment during childhood may assist with recovery from abuse, avoid the potential additional trauma that parental relinquishment of custody would cause, and improve the overall quality of life for abused children. DSHS provides a continuum of services, including outpatient and inpatient treatment. Examples include contracts with LMHAs to provide outpatient mental health services throughout the state, wraparound treatment planning based on the Systems of Care (SOC) model, mental health services in school-based health clinics, the YES Waiver, state hospitals, and the DFPS/DSHS Residential Treatment Center (RTC) Project. Effectively treating SED lessens the likelihood of parental relinquishment due to a SED. See Appendix C for details regarding intervention and treatment services.

Elimination of Waiting List in DSHS-Funded Community Mental Health System

Notably, while a waiting list for community-based mental health services provided through the LMHAs and some urban hospital districts has historically existed in Texas, the infusion of funding during the 83rd Legislature, Regular Session has virtually eliminated the waiting list in the entire state. Therefore, access to mental health services in community-based mental health system has been greatly improved.

DFPS/DSHS Partnership

The needs assessment completed by the University of Texas at Austin concludes that parental relinquishment due to SED is "a public health issue, not an issue for child protection." Although the provision of mental health treatment is the primary responsibility of DSHS, the reality is that this issue impacts all child-serving agencies. As such, DFPS and DSHS have found that the only successful approach to this dilemma has been to come together in true partnership and collaboration. Facilitation of improved working relationships is critical to impacting long-term systemic approaches that support children and families. Good working relationships have been formed through frequent and open communication, mutual respect for each other's expertise, and a shared mission and vision. DSHS and DFPS are collaborating on two such projects, including the DFPS/DSHS RTC Project and the DFPS/DSHS Substance Abuse Treatment Project. The relationship that DFPS and DSHS have cultivated over the past two years on these projects has led to other joint endeavors.

Strengthening Current Services

The current prevention, early intervention and treatment services are key parts of the solution to address mental health and prevent parental relinquishment due to SED. However, these services

[6] Nauert, R. (2008). Suicide Risk Among Abused Children. *Psych Central*. Retrieved on November 19, 2014, from http://psychcentral.com/news/2008/08/04/suicide-risk-among-abused-children/2685.html.

and access to these services can be strengthened. Examples of access or common problems with services include:

- therapist accessibility is largely dependent on insurance coverage;
- therapy is often child-focused instead of including the entire family;
- inpatient facilities are costly and insurance may refuse recommended length of stay;
- children who become involved with the juvenile justice system have their Medicaid terminated after thirty days and have a criminal justice history; and
- children who are placed in foster care experience additional trauma, and their parents are placed on the child abuse registry.

Recommendations

DFPS and DSHS offer the following recommendations based on barriers discussed above and other considerations referenced in the University of Texas at Austin needs assessment, collaborative partner contributions, and lessons learned:

Continue all services and initiatives currently provided for the prevention, early intervention, and treatment of SED

It is recommended that DFPS and DSHS continue current programs that are geared toward prevention, early intervention, and treatment of SED in children and youth. Decreasing the incidence of SED or treating it effectively would help preclude the family crises that might otherwise lead to parental relinquishment due to a child's SED. See Appendices for details regarding current services.

Build a More Complete Continuum of Care

Expand the DFPS/DSHS Residential Treatment Center Project

While prevention and treatment of SED is important to deterring parental relinquishment, a key recommendation of this report is to expand the DFPS/DSHS RTC Project.

The collaborative DFPS/DSHS RTC Project has been successfully diverting parents/guardians from relinquishing custody of their children with SED to DFPS by placing children who meet RTC criteria in DSHS-funded RTC beds. However, the 20 children on the RTC waiting list at the end of September 2014 exceed the current capacity of the RTC Project, which is funded for 10 ongoing beds in fiscal year 2014-2015. To date, the project has effectively prevented the relinquishment of 61 children since the project officially launched with the first RTC placement in January 2014.

It is recommended that the number of available RTC beds be increased by 20, for a total of 30 ongoing RTC beds per year. With an expected average length of stay of 6 months, about 60 children would be served per year and diverted from DFPS conservatorship. The 2016-2017 DSHS Legislative Appropriations Request (LAR) includes a request for $4.8 million to fund an additional 20 RTC beds. A total capacity of 30 beds would greatly reduce the amount of time children spend on the waiting list, which would also decrease utilization of psychiatric hospitalization, crisis services, and juvenile detention. A study funded by the National Institute of Mental Health found that 65 percent of boys and 75 percent of girls in juvenile detention have

at least one mental health disorder.[7] Finally, the risk of relinquishment of children by parents/guardians to DFPS would significantly decrease, as needed RTC services are expediently provided. While children receive RTC services, DSHS and DFPS should continue to ensure that RTCs are using effective treatment practices with children placed through the RTC Project, including the close coordination of family, RTCs, and outpatient services.

In addition to quality of life benefits that occur when children receive needed RTC services and reunify with their families, there are cost savings to the state when parental relinquishment of custody is prevented. In the RTC Project, the cost of six months of RTC services at $260.17 per day is $47,481. The annual cost to serve a child with SED in the foster care system is $93,661. In contrast, the annual cost to serve a child with SED in the community is $30,420. Thus, when a child completes DSHS-funded RTC services, reunifies with his family, and receives community-based mental health services, there is a cost avoidance to the state of $63,241 per year compared to a child with SED receiving care in the foster care system.

Fiscal Impact:

- The 2016-2017 DSHS LAR includes a request for $4.8 million for this expansion.

Policy:

- No policy change is needed to implement this recommendation.

Estimated Number of Children Affected:

- 80 children over the biennium

Continue to expand the Youth Empowerment (YES) Waiver

The YES waiver is a 1915(c) Medicaid Home and Community-Based Services (HCBS) waiver. The waiver provides home and community-based services to children/youth ages 3-18 that otherwise would need psychiatric inpatient care or whose parents are considering relinquishing custody to DFPS. The waiver allows inclusion of youth who are not otherwise Medicaid-eligible when living in the community (parental income is not included in financial eligibility calculation). The YES waiver array of services provides a more complete continuum of flexible community-based services and supports for children and adolescents with SED and their families and ensures access to other flexible non-traditional support services. Without access to the YES waiver, many children would not have access to this wide array of services that may be critical to improving their mental health and preventing crises that lead to more intrusive and costly interventions. Additionally, YES waiver utilizes high fidelity wraparound service planning (described in detail in Appendix C).

The YES waiver is currently available in ten counties throughout Texas, so at this time, its scope is limited to children in these geographic areas. In fiscal year 2014, 414 youth participated in YES waiver services. Since inception of the YES waiver, a total of 456 youth and their families have received YES waiver services.

[7] Teplin, L. Archives of General Psychiatry, Vol. 59, December 2002.

The YES waiver was initially implemented in fiscal year 2010 and the 83rd Texas Legislature allocated adequate YES waiver funding to support statewide expansion during the fiscal year 2014-2015 biennium. Pending approval from Centers for Medicaid and Medicare (CMS), the YES waiver is expected to be available statewide by September 2015.

Fiscal Impact:

- No additional funds are required, as these were allocated by the 83rd Texas Legislature.

Policy:

- No policy or statutory changes needed to continue the waiver through the next biennium; however, each time the program is expanded to a new geographical area, an amendment must be submitted to and approved by CMS.

Estimated Number of Children Affected:

- For fiscal year 2015, it is projected that 1,043 children will be served statewide.

Explore Expanding Community Resource Coordination Groups (CRCGs)

CRCGs originated when the 70th Texas Legislature, Regular Session, passed S.B. 298 into law in 1987. CRCGs are organized and established on a county-by-county basis. Agencies represented may include LMHAs, schools, juvenile probation, DFPS, private child-serving agencies, representatives from housing or workforce agencies, and others. Many CRCGs also include parents, consumers, or caregivers as members. CRCGs meet on a regular basis to plan specific services for children, youth, and adults whose needs have not entirely been met through existing resources and channels. Through collaboration between public and private agencies and organizations and family, consumer, and caregiver representatives, CRCGs improve coordination of community-based services for children, youth, and adults. CRCGs provide an opportunity for a child's needs to be more effectively discussed and addressed, potentially keeping the family's situation from escalating to the point of the child requiring residential treatment or a parent deciding to relinquish custody to DFPS.

Expansion of CRCGs is very cost-effective given the large number of children that could be impacted. An individual or a family may come to the local CRCG for individual service planning by any one of several routes. The person may be working with an assigned caseworker and a specific human service agency and find that additional assistance is needed. That person may either have multiple needs that fall under the missions of one or more additional agencies, or have difficulty accessing a specific service because they do not meet the eligibility guidelines. It could be a single individual or a whole family with a complex list of issues that comes to the CRCG for service planning. Several of the Texas communities that have developed a supportive cross-discipline system of care approach have used their county-based CRCGs as a portal for determining which children, youth and families would benefit from a more individualized wraparound team process. The county-based CRCGs are helpful for coordinating existing resources and services within a community, but they are different from an individualized child and family wraparound team. Currently there are approximately 160 local CRCGs available to all 254 Texas counties, though not all CRCGs have funding. Some have applied for external grants to fund their efforts, but many do not have a dedicated staff person to manage the CRCG or to provide service coordination for the population served. Additional state infrastructure

would be required for any expansion. In the future, DSHS will review data that have begun to be collected and consider expanding CRCG in high risk places.

Fiscal Impact:
- Administrative costs may be required.

Policy:
- No policy change is needed to implement this recommendation.

Estimated Number of Children Affected:
- To be determined.

Expand Crisis/Respite Services
Crisis and respite services are often a very necessary and helpful service to families who are struggling to meet the needs of a child with SED. Parents may have a difficult time identifying temporary caregivers who are willing and able to manage their child's behaviors and provide short-term respite or crisis care services. These services provide a temporary, safe place for a child to stay in times of crisis. They may also allow parents to recharge so that they are able to persevere long-term to manage the demands of parenting a child with SED. The DSHS LAR includes a request for $36.82 million in General Revenue over the course of the fiscal year 2016-2017 biennium to expand and enhance the availability of crisis services.

If funded, the resources will help enhance crisis services to assist in the integration of front-door mental health services and support regional collaborative plans and priorities. The funding will allow for local choice and options to address regional and community needs, and is intended to preclude the need to rely on costly and restrictive state-funded inpatient beds. Additionally, this expands crisis diversion options in areas of the state with no current DSHS or Delivery System Reform Incentive Payment (DSRIP) funded crisis facilities. (See Appendix C for more information about DSRIP.)

No policy or statutory changes will likely be required for this expansion, but additional training for staff to ensure that all mental health employees have knowledge regarding development in the young child through adolescent age span is advisable. Additionally, resource education and clear protocols for staff that make referrals are important aspects for utilization of crisis/respite services.

DSHS will explore gathering performance outcome data related to relinquishment prevention.

Fiscal Impact:
- The 2016-2017 DSHS LAR includes a request for $36.82 million to expand both crisis services for both children and adults.

Policy:
- No policy change is needed to implement this recommendation.

Estimated Number of Children Affected:

- 210 children over the biennium

Expansion of Training Opportunities

Deliver Mental Health First Aid (MHFA) training to DFPS Caseworkers

DFPS caseworkers may be one of the early contacts with a family involving a child with SED. One of the most important lessons learned in the DFPS/DSHS RTC Project was the need to support frontline child protection workers to identify SED, deliver effective crisis management, and access appropriate mental health services. More in-depth training on the early warning signs of mental health disorders, de-escalation techniques, and appropriate referral to mental health providers would better equip this workforce. It is recommended that existing MHFA certified trainers at LMHAs be utilized to provide this training to frontline child protection caseworkers at DFPS. MHFA training could first be targeted to those areas of the state that are identified as having a high prevalence of parental relinquishment of custody. This collaborative approach could also foster improved working relationships between DFPS and LMHAs.

Fiscal Impact:

- $85 per DFPS child protection caseworker

Policy:

- No policy or statutory change is needed to implement this recommendation.

Estimated Number of Children Affected:

- Actual number of children is undetermined, though children involved in the DFPS system are generally impacted by trauma which can cause or exacerbate SED.

Consider Additional Mental Health Training to Law Enforcement

The University of Texas at Austin needs assessment indicated the following as a barrier: "most law enforcement officers are not well trained to handle child mental health crisis, and may even escalate the situation." Training is recommended for law enforcement officers to ensure that they are equipped with a uniform skill set for recognizing and de-escalating children in crisis. Ultimately, this could lead to a decrease in the juvenile justice involvement of children and youth with SED and parental relinquishment due to SED.

Law enforcement officers trained to better understand youth with a mental illness could prove to be very positive for communities as officers de-escalate children without filing charges, resulting in children who are appropriately engaged in the mental health system rather than erroneously engaged in the juvenile justice system.

DSHS would offer outreach to law enforcement agencies to ascertain what, if any, additional training would be most appropriate and help determine the best implementation strategy.

Fiscal Impact:

- To be determined.

Policy:
- No policy or statutory change is needed to implement this recommendation.

Estimated Number of Children Affected:
- Mental health training for law enforcement officers could potentially impact thousands of children in Texas.

Provide Cross-agency Training on Mental Health Resources/LMHA Services
DFPS caseworkers, educators, law enforcement and probation officers, and primary care providers have frequent contact with children and families. In addition to MHFA training, it is recommended that these individuals receive training regarding the mental health resources that are available in their communities. Connecting children with early mental health intervention could provide the support that families need to prevent them from considering relinquishing custody of their child to DFPS in the future.

DFPS and DSHS have already developed training on community mental health resources for DFPS staff and community members. To disseminate this training more broadly, webinars and DVDs could be utilized at no cost to the state.

Fiscal Impact:
- No fiscal impact.

Policy:
- No policy or statutory change is needed to implement these models

Estimated Number of Children Affected:
- Cross-agency training could potentially impact thousands of children in Texas.

Enhancements to DFPS Practice

Increase DFPS consideration of Joint Managing Conservatorship
DFPS should develop and disseminate guidance for DFPS staff regarding the option to discuss Joint Managing Conservatorship with families who meet statutory criteria. Texas law allows a family court to name DFPS and a family as "joint managing conservators" (JMC) of a child who must be removed from the home.[8] The law also directs DFPS to discuss with a person relinquishing custody of a child in order to obtain mental health services the option of seeking a court order for JMC if it is in the best interests of the child.[9] Historically, DFPS has not been able to keep data on the number of families who share JMC with the agency. In May 2014, DFPS added a mechanism to the state's child welfare information management system that will now allow for such tracking. At this point in time, anecdotal evidence suggests that JMC is used sporadically throughout the state when considered to be appropriate.

This option is currently being implemented with existing resources. No statutory change is needed to allow the use of JMC, but DFPS should adopt guidance to staff regarding in what

[8] Texas Family Code Sec 153.372
[9] Texas Family Code Sec 262.352 (enacted by S.B.44, 83rd Legislature, 2013)

circumstances it might be appropriate for the agency's legal representative to request that the judge appoint DFPS and the parent(s) as JMC.

Fiscal Impact:

- Because the decision to award JMC is ultimately made by a judge, DFPS is unable to determine how much the fiscal impact will be if more families utilize this option, if any.

Policy:

- No policy change is needed to implement this recommendation.

Estimated Number of Children Affected

- Because the decision to award JMC is ultimately made by a judge, DFPS is unable to determine at this time how many children and families may be affected by an increased use of the JMC option.

Make Information on Parental Rights Regarding Relinquishment More Readily Available

DFPS should make information regarding parents' rights in the child protection system and the consequences of relinquishment available to families who may be considering relinquishing custody of their child to DFPS solely for the purpose of obtaining mental health services. The current Texas state child welfare system does not provide for "voluntary relinquishment" whereby a family can ask DFPS to take custody of their child without abuse or neglect conditions being present. Children currently only come into foster care if all of the following three conditions are met:

- abuse or neglect has been confirmed, or DFPS has evidence that there is an immediate danger to the physical or safety of the child or the child has been a victim of neglect or sexual abuse;
- DFPS has made reasonable efforts to prevent removal; and
- a court has ruled that removal from the home is necessary for the child's welfare.

In most instances in which a family seeks to relinquish custody to obtain mental health care, a DFPS investigation finds that the parents' actions or omissions involving the child meet the statutory definitions of abuse or neglect. This results in the caregiver's name being placed on the Texas child abuse central registry. At the end of an investigation, DFPS sends the parent a letter informing them about the abuse or neglect finding, which includes information regarding their legal right to appeal the finding through an Administrative Review of Investigation Findings (ARIF).[10] If the ARIF upholds the finding, the person is notified in writing that they can appeal the finding through the DFPS Office of Consumer Affairs. If the finding is overturned in either review, DFPS takes the person's name off of the central registry.

Inclusion on the registry can impact the caregiver's ability to work in certain DFPS programs or DFPS regulated child care or 24-hour care facilities. This is only in the instances where Texas law or rule requires a central registry check to be conducted on potential or current employees or volunteers for that type of program or facility. It could also impact the caregiver's ability to foster or adopt children in the future from DFPS or independently, as individuals seeking to become approved foster or adoptive parents must have a central registry check conducted. Because of

[10] Texas Family Code Sec 261.309, Review of Department Investigations.

these consequences of relinquishment, more could be done to ensure parents are made aware of their rights in the DFPS child protection system and the consequences of relinquishment so they can make an informed decision about pursuing relinquishment of the child to DFPS.

Fiscal Impact:
- No fiscal impact.

Policy:
- No policy change is needed to implement this recommendation.

Estimated Number of Children Affected:
- It is unknown how many families would choose not to relinquish custody if more information regarding the possible consequences of having a finding in the DFPS central registry were made available to them.

Summary

As initially outlined, S.B.44 directed DFPS and DSHS to jointly study and develop recommendations to prevent the practice of parents relinquishing custody of children with SED to the conservatorship of DFPS solely to obtain mental health services for the child. What the needs assessment and the report confirmed is not surprising. This is a complicated issue that impacts not only the children/youth and families, but all child-serving agencies and the State, as a whole.

A multi-factorial issue often calls for a multi-pronged approach. As to the issue of SED in children and adolescents, DSHS has an array of initiatives and services listed in the above report that range from prevention, early intervention, and treatment, including both outpatient and inpatient services. Despite the challenges that often face these systems, DSHS has continued to revise, redesign, and improve upon these services. When SED is prevented, identified early, and effectively treated, parents are not faced with the difficult decision of relinquishing their parental rights due to a child having SED and the inability to obtain appropriate services for them.

Lastly, the report outlines a number of recommendations for consideration as follows:
- continue the current DSHS and DFPS services and initiatives geared toward prevention, early intervention, and treatment of SED in children and youth;
- increase the number of residential treatment center beds for the DFPS/DSHS Residential Treatment Center Project;
- explore expanding Community Resource Coordination Groups in high risk areas;
- continue to expand the YES waiver;
- expand emergency crisis and respite services;
- expand mental health training opportunities for professionals who have frequent contact with children such as DFPS child protection caseworkers, educators, and law enforcement;
- increase DFPS consideration of Joint Managing Conservatorship for families who meet statutory criteria; and
- make information on parental rights regarding relinquishment more readily available.

The recommendations primarily entail expanding existing initiatives or programs. As indicated in the report, some of these recommendations are already being implemented or are in progress. Policy and possible statute changes may be needed in some instances. Additionally, while some of these can be done with existing resources, others will require additional funding. In some cases, DSHS has already included a number of these for consideration in their LAR. The needs assessment showed that, although this is an expensive issue to address, it is more expensive and detrimental not to address.

Unfortunately, there are numerous families who face the dilemma of considering whether to relinquish custody of their child to DFPS to obtain needed mental health services. It is for that reason that DFPS and DSHS came together prior to the 83rd Legislative, Regular Session to explore options to address the plight of these children and families. From this, DSHS proposed the DFPS/DSHS RTC Project, which was funded and is described in detail in Current Services and Initiatives and in Appendix C.

Appendices

Appendix A: Prevention Services

Department of State Health Services

Improving Outcomes for Individuals Affected by Prenatal Substance Exposure across the Lifespan

The following are initiatives that will affect DSHS-funded substance abuse intervention programs in the near future:

- DSHS will conduct a statewide training for DSHS-funded substance abuse services providers and primary care providers on replicating an integrated model of care that has resulted in improved outcomes for newborns with a diagnosis of Neonatal Abstinence Syndrome (NAS), including a reduction of neonatal intensive care unit lengths of stay and reduction of DFPS removals.
- DSHS will conduct a corresponding study to formalize standards of care for substance-exposed newborns and birth parents.
- DSHS will conduct a statewide training for DSHS-funded substance abuse treatment providers and Local Mental Health Authorities (LMHAs) on screening and treatment modification for youth and adults with neurodevelopmental and neurobehavioral disorders associated with prenatal substance exposure.
- In the 2016-2017 Legislative Appropriations Request (LAR), DSHS includes a request to expand existing intervention, treatment, and outreach services, as well as create new services and systems aimed at reducing the incidence and severity of NAS and improving preservation among families impacted by NAS.

Substance Abuse Prevention

"Available data indicates that adolescents who have a substance abuse disorder have an increased risk of experiencing other mental disorders (Beitchman, 2001). In fact, Wise (2001) points out that the majority of adolescents with substance abuse disorders have a current anxiety, mood or disruptive disorder. Conduct disorders and mood disorders are the two disorders most consistently reported (Wise, 2001)."[11]

Direct-service Youth Prevention (YP) programs promote the avoidance of substance abuse by providing education, skill-building, pro-social bonding, and techniques that foster family bonding through face-to-face interactions. DSHS currently funds 133 YP programs. These serve participants ages 6-18 and young adults that are in school and meet the curriculum and program criteria. Contracted prevention providers utilize ten evidence-based curricula [National Registry for Evidence Based Programs and Practices (NREPP) approved] to deliver these services in 173 (68 percent) of the 254 Texas counties. In fiscal year 2014, these programs served 1,609,667 youth and 496,923 adults.

[11] Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services http://www.samhsa.gov/reports/congress2002/chap4icacd.htm

In an effort to expand access to YP programs, the 2016-2017 DSHS LAR includes a request for $24.7 million over the biennium to fund the additional direct-service YP programs by 122 new programs in counties that currently do not have any substance abuse prevention services.

Department of Family and Protective Services, Prevention and Early Intervention

Services to At-Risk Youth (STAR)

The STAR program contracts with community agencies to offer family crisis-intervention counseling, short-term emergency respite care (temporary relief for those who are caring for at-risk youth), and individual and family counseling. Youth as old as age 17 and their families are eligible if they experience conflict at home, truancy or delinquency, or if a youth runs away from home. STAR services are available in all 254 Texas counties. Each STAR contractor also provides universal child abuse prevention services, ranging from local-media campaigns to informational brochures and parenting classes.

In fiscal year 2013, the STAR program served 23,677 youth and 19,150 primary caregivers.

Community-Based Family Services

This program serves families who are investigated by DFPS child protection caseworkers, but allegations are not confirmed. Services include home visits, case management, and additional social services to promote a safe and stable home environment.

In fiscal year 2013, the Community-Based Family Services program served 287 families.

Texas Families: Together and Safe

This program funds evidence-based, community programs to relieve stress and promote parental skills and behaviors that increase the ability of families to be independent and successfully nurture their children. The goals are to:

- improve and enhance access to family support services;
- increase the efficiency and effectiveness of community-based family support services;
- enable children to stay at home by providing preventive services; and
- increase collaboration among local programs, government agencies, and families.

In fiscal year 2013, the Texas Families: Together and Safe program served 1,736 families.

Appendix B: Early Intervention Services

Public Awareness Campaign

The 2014-2015 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, appropriated $1.6 million for a behavioral health public awareness campaign. The goals of the campaign are to:

- build broad awareness about the problem of mental illness and substance abuse disorders among teens and young adults in communities across Texas;
- demystify mental illness by making it familiar and educating people that it's treatable; and
- equip teen support systems to understand mental illness is common among youth, recognize warning signs of mental illness and substance use disorders, and take action by referring teens and young adults to qualified sources for treatment.

The primary target audience is the support network for teens and young adults. The secondary target audience is teens and young adults. The campaign materials are designed to start the conversation between the two audiences. These messages are captured in the campaign slogan "Speak Your Mind Texas." The campaign consists of print materials, online media, and website (www.speakyourmindtx.org), also available in Spanish. Sixteen Community Conversations across the state were held in fiscal year 2014. Additionally, DSHS is partnering with 2-1-1 as a resource for people seeking local mental health resources and services.

The current plan for fiscal year 2015 is to continue with 16 more Community Conversations, more online and digital advertising, a continued partnership with 2-1-1, and a post-campaign evaluation. Additionally, in the DSHS 2016-2017 LAR a request related to behavioral health prevention, which includes $1.5 million over the biennium to expand the implementation of the "Speak Your Mind" public awareness campaign to include the state's three substance abuse prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs.

At-Risk Training

DSHS funded the development of At-Risk Training for High School and Middle School Educators, which has been added to the Substance Abuse and Mental Health Services Administration (SAMHSA) NREPP. These one-hour, online, interactive gatekeeper[12] training programs prepare high/middle school teachers and other school personnel to identify, approach, and refer students who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse, and suicidal ideation and behavior. This program is provided free to Texas educators and can be a component of a school district's Suicide Prevention Plan, as required by H.B.1386 (82nd Legislature, Regular Session, 2011).

Since their creation, Texas has trained 27,300 public middle and high school teachers in the At-Risk training (16,821 high school teachers trained since 2010 and 10,484 middle school teachers trained since 2012). Currently, there is no training available specifically targeted for elementary

[12] In suicide prevention, a gatekeeper refers to someone who knows basic information about suicide, believes that suicide can be prevented, learns basic suicide intervention skills, has the confidence to respond, and can assist in the aftermath of a suicide. They can be teachers, counselors, ministers, youth workers, parents, or anyone.

educators. As such, DSHS has included a request for $336,649 in its LAR for the At-Risk Online Training for Elementary Educators.

Mental Health First Aid (MHFA)

House Bill 3793, 83rd Legislature, Regular Session, directed DSHS to provide grants to LMHAs to train their staff and contractors as instructors of MHFA. Additionally, these MHFA instructors are then to provide training in the MHFA protocols to educators at no cost. The 2014-2015 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session (Article II, DSHS Rider 84) appropriated $5 million for this purpose. MHFA is an EBP according to SAMHSA's NREPP. The intent of the legislation is to provide participants with the skills necessary to assist an individual experiencing a mental health crisis until the individual is able to obtain appropriate professional care and to maximize the number of youth exposed to professionals trained in MHFA. Since the MHFA program was implemented in December 2013:

- 414 LMHA staff members or their contractors have been certified as trainers of MHFA;
- 7,851 educators have completed MHFA training; and
- 2,616 non-educator community members have completed MHFA training.

Centers have submitted plans for fiscal year 2015 and seek to:

- Certify 206 additional staff members or contractors as trainers of MHFA; and
- Train an additional 11,257 educators in MHFA.

Appendix C: Treatment

Outpatient

DSHS-funded Community-Based Mental Health Services

DSHS contracts with 37 LMHAs and one Local Behavioral Health Authority (LBHA) in the Dallas area (NorthSTAR) to provide comprehensive outpatient mental health care services throughout all 254 counties in Texas. In fiscal year 2014, these providers served 54,576 children/youth.

In fiscal year 2014, DSHS rolled out a new service delivery system for children's public mental health services in Texas, known as the Texas Resilience and Recovery (TRR). There are three core components to TRR:

- Child and Adolescent Needs and Strengths (CANS) assessment;
- Level of Care (LOC) based on intensity of child and family need; and
- A broadened array of services emphasizing evidence-based and promising practices.

Under the new TRR model and as a part of the performance contract, all LMHAs are required to have a least one Certified Family Partner on staff. This specialized peer role has been created to assist and support parents/guardians to navigate public systems. A family partner is a person who has real life experiences parenting a child with mental, emotional, or behavioral health disorders and can articulate the understanding of their real life experiences with another parent or family member. As mentors and role models, certified family partners are ideal providers of family skills training, and/or medication training and support to the caregiver/parent, which benefits the child or youth. This can be essential to those considering parental relinquishment.

TRR is better equipped to identify the needs of children and families, particularly those at high risk. Once identified, they are provided with the most intensive level of care which utilizes high-fidelity wraparound treatment planning. Providing the right services in the right dose provides for better outcomes for children and youth with SED.

High-Fidelity Wraparound

Wraparound treatment planning was implemented statewide using the National Wraparound Initiative (NWI) model beginning in September 2013. Wraparound is an intensive, individualized care planning and management process. This is an evidenced-informed approach that supports a set of core values and principles which are based on the Systems of Care (SOC) model (discussed below). Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. This is designed for youth with complex needs and multisystem involvement who are at risk of being removed from their home or community. As such, wraparound has shown to be a viable outpatient community-based option for some children with SED whose parents were considering relinquishing their parental rights in order to access appropriate mental health care.

Since the implementation of wraparound in the state of Texas there are:

- 385 trained facilitators;
- 75 trained wraparound supervisors;
- 11 coaching candidates currently supported by NWI in the process of becoming certified;
- 7 LMHAs currently receiving coaching support; and
- 236 youth currently being served or have been served with wraparound treatment planning.

System of Care (SOC)

The Texas System of Care initiative is based on "system of care," which is an organizational philosophy and framework that involves collaboration across agencies, families, and youth. The purpose is to improve access and to expand the array of coordinated community-based services and supports for children and youth with SED. The SOC approach focuses on community planning to coordinate public and private organizations to design mental health services and supports that are effective. The principles of the SOC philosophy specify that services are community-based, family-driven, youth-guided, individualized, coordinated, and culturally and linguistically competent. Service coordination is an element of SOC, and wraparound treatment planning process is utilized. There are seven Texas communities who are implementing SOC approach with the assistance of current or former federal funding. Those communities are: Travis County, North Central Texas, El Paso County, Harris County, the Panhandle region, Bexar County, and the lower Rio Grande Valley region.

The ultimate purpose of the SOC is to enable children and youth with mental health challenges and their families to function well in their homes and communities and to lead productive lives. Over the past decade, the system of care approach has increasingly been adopted by behavioral health, child welfare, education, juvenile justice, and health systems serving young children, youth, and families. The SOC approach and services can prevent parental relinquishment due to SED.

Community Resource Coordination Group (CRCG)

On the local level, the CRCG is an example of a multi-agency collaboration. CRCGs originated when the Texas Legislature passed S.B.298 into law in 1987. CRCGs are organized and established on a county-by-county basis. Agencies represented may include LMHAs, schools, juvenile probation, DFPS, private child-serving agencies, representatives from housing or workforce agencies, and others. Many CRCGs also include parents, consumers, or caregivers as members. CRCGs meet on a regular basis to plan specific services for children, youth, and adults whose needs have not entirely been met through existing resources and channels. Through collaboration between public and private agencies and organizations and family, consumer, and caregiver representatives, CRCGs improve coordination of community-based services for children, youth, and adults. An individual or a family may come to the local CRCG for individual service planning by any one of several routes. The person may be working with an assigned caseworker and a specific human service agency and find that additional assistance is needed. That person may either have multiple needs that fall under the missions of one or more additional agencies, or have difficulty accessing a specific service because they do not meet the eligibility guidelines. It could be a single individual or a whole family with a complex list of issues that comes to the CRCG for service planning. A CRCG meeting is held to develop a CRCG service plan *in partnership* with the referred individual and/or family utilizing a wraparound treatment planning

approach in order to ensure children and their families get services and support. These resources may assist families of children or youth with SED in maintaining them in their own home and community, thereby preventing parental relinquishment. There are approximately 160 local CRCGs available to all 254 Texas counties. The level of activity of these individual CRCGs varies.

Telehealth

Workforce shortages in Texas impact the availability of mental health providers to identify and treat children/youth with SED in many counties throughout the state. In 2011, telehealth and telemedicine mental health services were expanded in Texas through S.B. 293. This bill expanded Medicaid services to include the use of telehealth to provide mental health services by licensed mental health professionals. It also expanded telemedicine services by psychiatrists and licensed health professionals within the scope of their license. This allows for children and families throughout Texas to access mental health services even when there are shortages of mental health professionals in their communities. This accessibility of mental health services to all children in Texas helps treat SED; therefore, reduces the risk of parental relinquishment.

Mental Health Services in School-Based Health Clinics (SBHC)

A school based health center (SBHC) is one way to address how children access mental health services. Three of the 80 SBHCs in Texas are funded by DSHS and two of the three DSHS funded centers are providing mental health services in addition to primary healthcare. The SBHCs are all independently run and operated; therefore, there is no single warehouse for all of their data. Additionally, each program is uniquely structured such that some may serve children from a single school while others may serve children from entire counties. The DSHS-funded SBHCs are:

- Chambers County Public Hospital District (provide MH services);
- Plainview Foundation of Rural Health (provide MH services); and
- Houston ISD.

In fiscal year 2014, there were 539 mental health encounters. Four hundred thirty-seven of these encounters were for students and 102 encounters were for siblings or family members of the students. Additionally, 42 referrals to other mental health providers were made. Some children may not receive mental health services if these were not provided within the school through the SBHC.

Crisis Services

DSHS has crisis services for children/adolescent receiving LMHA services that are in imminent danger to themselves or others, or believe that they are experiencing a mental health crisis. Individuals in a crisis level of care have access to the following resources: crisis intervention services, psychiatric evaluation and examination, pharmacological management, crisis transportation, safety monitoring, day programs for acute needs, extended observation, crisis residential treatment, crisis stabilization unit, crisis flexible benefits, in-home respite services, facility-based respite services, inpatient hospital services, psychiatric emergency room services, and crisis follow up and relapse prevention. These services can be essential for parents of children with SED.

Each of the 37 LMHAs and NorthSTAR receive funding to provide hotline and mobile crisis outreach services in their communities. The 24/7 hotline serves as the first point of contact for mental health crisis in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services if necessary.

The 2014-2015 General Appropriations Act, SB 1, 83rd Legislature, Regular Session, allocated $25 million in new funds to expand or enhance alternatives to hospitalization, emergency rooms, or jail through the development of crisis projects. Funds were used to expand crisis projects in 16 LMHA service areas. Currently, 29 LMHAs and NorthSTAR utilize DSHS funding to support crisis facilities. Preliminary data indicates there were 21,119 crisis interactions in fiscal year 2014.

There are currently three crisis/emergency respite sites that serve the child/adolescent population:

- Tarrant County Mental Health and Mental Retardation's (MHMR) crisis/respite center opened in December 2013 with 12 beds and has served 235 youth;
- Spindletop MHMR in Jefferson County opened a 16-bed Youth Crisis Center in May 2014 and has served 34 youth; and
- Bexar County opened a 16-bed crisis/respite center in October 2014. They are in partnership with DFPS and Texas Department of Juvenile Justice (TJJD) to provide step down respite services and crisis services for children in need.

Youth Empowerment Services (YES) Waiver

The YES waiver is a 1915(c) Medicaid Home and Community-Based Services (HCBS) waiver. The waiver provides home and community-based services to children/youth ages 3-18 that otherwise would need psychiatric inpatient care or whose parents are considering relinquishing custody to DFPS. The waiver allows inclusion of youth who are not otherwise Medicaid-eligible when living in the community (parental income is not included in financial eligibility calculation). The YES waiver array of services provides a more complete continuum of flexible community-based services and supports for children and adolescents with SED and their families and ensures access to other flexible non-traditional support services.

The YES waiver is currently available in ten counties throughout Texas with plans for further expansion beginning in January 2015. In fiscal year 2014, 414 youth participated in YES waiver services. Since inception of the YES waiver, a total of 456 youth and their families have received YES waiver services. Some families who met criteria for participation in the DFPS/DSHS Residential Treatment Center Project chose to engage in YES waiver services instead of RTC placement. YES waiver services are also utilized while children are on the waiting list for RTC placement. In both cases, YES waiver services are instrumental in treating the mental health needs of children and helping their families to no longer consider parental relinquishment as a potential solution.

Delivery System Reform Incentive Payment (DSRIP) Projects

Texas has a five-year Medicaid demonstration waiver (through September 30, 2016) that will enable hospitals and other providers to earn up to $11.4 billion all funds for Delivery System Reform Incentive Payment (DSRIP) projects. DSRIP is an incentive program to transform delivery systems through infrastructure development and testing innovative care models. The DSRIP program under Texas' 1115 Medicaid Transformation Waiver has enabled almost 1,500 projects across the state to improve healthcare delivery systems, including improving access to care, quality of care, and health outcomes.

Of the four-year DSRIP projects, almost one third (389) have a behavioral healthcare focus, including:

- 90 interventions to prevent unnecessary use of services (in the criminal justice system, emergency departments, etc.);
- 58 projects to enhance behavioral health service availability (hours, locations, transportation, mobile clinics);
- 49 projects to develop behavioral health crisis stabilization services;
- 49 projects to integrate primary and behavioral care services; and
- 40 projects to deliver behavioral health care services through telemedicine/telehealth.

Approximately 75 percent of the 4-year behavioral health projects are being performed by community mental health centers and the other 25 percent by hospitals and other DSRIP providers.

Examples of behavioral healthcare projects from the regions:

- MHMRA of Harris County: Add three additional teams to the Crisis Intervention Response Team, which partners law enforcement officers with master-level clinicians to respond to law enforcement calls.
- Tropical Texas Behavioral Health: Develop primary care clinics co-located within three Tropical Texas clinics.
- Center for Health Care Services (San Antonio): Establish a centralized campus from which systems or families can obtain care for children and adolescents with a serious emotional and/or behavioral problem or developmental delay.
- Metrocare (Dallas): Integrate behavioral health into the outpatient obstetrics setting to provide increased access to mental health services for the treatment of postpartum depression.
- Texas Panhandle Centers: Provide a 24/7 crisis respite program, focusing on rapid stabilization and averting future crises.

DSRIP projects are still early in their implementation. More will be known about their impact in the next two years as data on quantifiable patient impact and outcomes are available. Some of these projects may prove very helpful to children with SED and their parents, thereby reducing parental relinquishment due to SED.

Residential and Inpatient

State Hospitals/Waco Center for Youth

DSHS funds residential treatment beds for adolescents at the Waco Center for Youth and psychiatric hospital beds for acute treatment and stabilization across the state. State funded psychiatric hospitals that serve children and/or adolescents are located in Austin, El Paso, Vernon, Wichita Falls, San Antonio, Terrell, and Houston. In South Texas, the Rio Grande State Center serves persons with Intellectual and Developmental Disorders (IDD) as well as providing mental health services. The services provided by these facilities to treat children and youth with SED are critical and may prevent parental relinquishment due to SED.

DFPS/DSHS Residential Treatment Center (RTC) Project

Accessible RTC services are essential for preventing families from relinquishing custody of their children with SED when many other treatment options have failed and RTC placement is medically necessary. In support of improving accessibility, the 2014-2015 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 allocated $2.1 million to DSHS to fund ten beds in private RTCs for children and youth referred to DFPS who are at risk for parental relinquishment of rights due solely to a lack of mental health resources. The intent of this program is twofold:

- to serve children and youth who suffer from SED, who are reported as victims of abuse or neglect with DFPS investigations resulting in no findings, and whose parents cannot access RTC placement due to a lack of family resources; and
- to make reasonable efforts to prevent the parents relinquishing custody to DFPS solely to obtain mental health services for the child or youth.

RTC placement is utilized when community intervention is not able to meet the mental health needs of a child and the child's mental health symptoms make it unsafe for the family to care for the child in the home. RTC services are delivered in a safe therapeutic environment with 24-hour supervision, and include individual, group, and family therapy; recreation therapy; psychiatric consultations; and medication management. Staff providing 24-hour supervision assist children to de-escalate from stressful situations and learn healthy social skills. Some RTCs also provide adjunct therapies, such as music, dance/movement, and art therapy. Substance abuse prevention groups are often held for children, and specialized RTCs can also provide treatment for substance use disorders when clinically indicated. While children receive RTC services, DSHS regularly conducts utilization management reviews to ensure that RTCs are providing effective treatments and meeting contractual obligations.

In this RTC Project, DSHS and DFPS have closely collaborated to prevent parental relinquishment of custody of children and youth with a SED to DFPS solely to obtain mental health treatment. All referrals originate from DFPS and to date, over 750 DFPS child protection caseworkers have been trained on the RTC referral process. DSHS receives the referrals from DFPS and coordinates mental health assessments for the children with their LMHA. Children who do not meet RTC criteria are offered outpatient services at the appropriate level of care by the LMHA, while children and families who do meet RTC criteria are offered outpatient services while awaiting RTC placement. Between October 15, 2013 and September 30, 2014, 48 children met RTC criteria. In fiscal year 2014, 14 children were served in RTC placements and 5 of those children were discharged with family reunification plans. The remaining nine children continue

to receive RTC services. While children receive RTC services, the RTCs and LMHAs work together to provide parents/guardians with the skills they will need to be successful upon reunification with their children. In addition to the children served in RTCs, seven children referred by DFPS have been able to remain in their homes due to wraparound and increased community services from the LMHAs.

One of the seven children who were able to remain at home was on the RTC waiting list for about two months. During the waiting period, the LMHA provided wraparound services and worked closely with both the youth and his mother. Ultimately, the family decided to continue with wraparound services, which were benefitting their son, and requested to be removed from the RTC waiting list.

At the end of September 2014, 10 children and youth were in RTC placement and another 20 children were on the waiting list. To help support families on the waiting list, LMHAs and NorthSTAR offer outpatient services, wraparound, and, where available, the YES waiver program to those families who consent. Additionally, CRCG meetings are convened to identify supplemental community resources.

Parents/guardians of children on the RTC waiting list frequently inquire whether an RTC bed has become available as outpatient services are often not sufficient to treat the severity of their child's SED symptoms. As a result, children who are on the RTC waiting list are at increased risk of parental relinquishment of custody. Some children have been on the waiting list for longer than six months and their families' stress levels have continuously remained high while struggling, even with outpatient services, to maintain the safety of their child with SED. Psychiatric hospitalization, crisis services, and juvenile detention have been utilized as needed to resolve emergent mental and behavioral health symptoms for the children pending RTC placement.

The availability of RTC beds is extremely important for helping families to avoid relinquishment of their children with SED. In August 2014, several children in the DFPS/DSHS RTC Project were discharged from RTCs to their families, resulting in open RTC beds. At the same time, DFPS referred a child whose parents were considering relinquishing custody of her to DFPS in the very near future because residential treatment was clinically indicated for her SED symptoms. A DFPS representative for the RTC Project met twice with the family to explain the referral process and offer support. In this case, it was fortunate that a bed was available due to the recent discharges. DSHS applied to RTCs for this child and she was rapidly admitted at the beginning of September 2014. Following placement, the parents expressed their gratitude to both DFPS and DSHS for their helpfulness and patience. This family remained intact because an RTC bed was available, but had their child been required to join an extensive waiting list, the final outcome may not have been as positive.